TRICARE PRIME REMOTE (TPR)
ENROLLMENT FORM

PLEASE PRINT ALL INFORMATION

ACTIVE DUTY SPONSOR INFORMATION

PERSONAL DATA - PRIVACY ACT OF 1974

This form is used to enroll the active duty member into the TRICARE Prime health care system & CHCS computer system.

❒ YES, I AM TRANSFERRING FROM ANOTHER TPR REGION ❒ NO, I AM NOT TRANSFERRING FROM ANOTHER TPR REGION

1) NAME: (Last, First, MI)	2) SPONSOR SSN:	3) GENDER: ❒ MALE ❒ FEMALE

4) DATE OF BIRTH: (DD-MM-YY)	5) SPONSOR SERVICE: ❒ USAF ❒ USA ❒ USN ❒ USMC ❒ USCG	6) SPONSOR STATUS ❒ ACTIVE DUTY ❒ RESERVE ❒ NATL GUARD	7) PAY GRADE:

8) HOME ADDRESS: STREET	CITY	STATE	ZIP
9) MAILING ADDRESS: STREET	CITY	STATE	ZIP

10) HOME PHONE:	11) WORK PHONE:

12) UNIT OF ASSIGNMENT NAME (See items 12-13 on reverse to be sure you insert correct command level):

13) UNIT OF ASSIGNMENT ADDRESS: STREET	CITY	STATE	ZIP

14) ARRIVAL DATE: (DD-MM-YY)	15) UNIT POC:	16) UNIT FAX:	17) UNIT POC E-MAIL:	18) DSN:

19) PRIMARY CARE MANAGER NAME:

20) PRIMARY CARE MANAGER ADDRESS: STREET	CITY	STATE	ZIP

21) ***PLEASE INITIAL EACH ITEM BELOW TO ACKNOWLEDGE YOUR AGREEMENT. SIGN AND DATE ON THE SIGNATURE LINE BELOW.***

_____ I have read the information provided to me in the TRICARE Prime Remote Handbook, The Remote Controller, and hereby apply for enrollment. I understand my responsibilities as an Active Duty service member in regards to the TRICARE Prime Remote Program and will ensure that all information is current and correct in the Defense Enrollment Eligibility Reporting System (DEERS).

_____ I understand that, except for emergencies, all TRICARE Prime Remote services must be coordinated through the PCM or Health Care Finder.

_____ I authorize Foundation Health Federal Services and/or its provider network subcontractor(s) to examine, disclose and copy records of any physician, hospital or provider when necessary for proper payment of benefits for all enrollees listed on this application and/or attachment.

_____ I hereby certify that the information provided on the document is true and complete. I agree to abide by the provisions of membership in TRICARE Prime Remote.

SIGNATURE: _____ **DATE:** _____

KEEP A COPY FOR YOUR RECORDS AND RETURN ENROLLMENT FORM TO:

Foundation Health Federal Services
Attn: Region 9, 10, & 12 TRICARE Enrollment
P.O. Box 2890
Rancho Cordova, CA 95741-2890
(800) 242-8788 FAX: (916) 351-4025

TRICARE Prime Remote Enrollment Instructions

Please print in ink all information for the Active Duty Service Member. If the information provided does not match what DEERS has on file, or if information is missing, your application may be delayed. If you need assistance, please call us at (800) 406-2832, and a representative will be happy to assist you.

This form does not enroll family members into TRICARE Prime. If you are interested in enrolling your family, please visit your local TRICARE Service Center or call us toll-free at (800) 406-2832 to obtain information on TRICARE options available to your family members in your area.

MAKE SURE ALL INFORMATION IS COMPLETE AND ACCURATE.

1. ACTIVE DUTY SERVICE MEMBER NAME – Last name, first name, middle initial.

2. ADSM SSN – Active Duty Service Member Social Security Number.

3. GENDER – Select appropriate box to reflect the gender of the ADSM.

4. DATE OF BIRTH – Active Duty Service Member birthdate (Day, Month, Year).

5. SPONSOR SERVICE – Check the appropriate box. This is found on your United States Uniformed Services card.

6. SPONSOR STATUS – Check the appropriate box. This is found on your United States Uniformed Services card.

7. PAY GRADE – Active Duty Service Member pay grade. This is found on your United States Uniformed Services card.

8. HOME ADDRESS – Street, Apt. Number, City, State, Zip Code. A RESIDENCE ADDRESS IS REQUIRED. This is the place where you physically go home to on a daily basis.

9. MAILING ADDRESS - Street, Apt. Number, City, State, Zip Code. Only required if different than HOME ADDRESS or if mail needs to be sent to a different address.

10. HOME TELEPHONE NUMBER – Area Code, Prefix, Suffix.

11. WORK TELEPHONE NUMER – Area Code, Prefix, Suffix.

12-13. UNIT OF ASSIGNMENT – Name and address of your unit. This is the place where you physically go to work on a daily basis; not the command address. The Unit address stamp or sticker should be applied, if available.

14. ARRIVAL DATE – The actual date (Day, Month, Year) you arrived into this TRICARE Prime Remote Unit.

15. UNIT POC – The Unit Point of Contact upon arrival into the TRICARE Prime Remote Unit.

16. UNIT FAX NUMBER – The Unit POC fax number.

17. UNIT POC E-MAIL – The Unit POC E-mail address.

18. DSN – The Unit POC DSN.

19. PRIMARY CARE MANAGER (PCM) – This is the network provider, if available, selected from the directory. If a network provider is available in your area, and no PCM is selected, one will be assigned. Only list a network PCM (if applicable) in this block. If there is not a network provider for primary care, leave this block blank.

20. PCM ADDRESS – List the Primary Care Manager's complete address including street, city, state and zip code. Leave this block blank if a network PCM is not identified in block 19 above.

21. Please review and initial each item to acknowledge your agreement. TPR Active Duty Service Members will be enrolled for the duration of the duty assignment. The TRICARE Prime Remote enrollment application must be signed by the Active Duty Service Member or the Unit Commander.